

# MEDICAID AND FAMIS-PLUS HANDBOOK



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**Mission Statement:** *To provide a system of high quality comprehensive health services to qualifying Virginians and their families.*

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## GENERAL INFORMATION ABOUT MEDICAID AND FAMIS PLUS

Medicaid and coverage for children under FAMIS Plus are programs that help pay for medical care. To be eligible for Medicaid or FAMIS Plus you must have limited income and resources and you must be in one of the groups of people covered by Medicaid. Some groups covered by Medicaid are: pregnant women, children, people with disabilities, and people age 65 and older.

Medicaid and FAMIS Plus are programs funded by the state and federal governments. Not everyone with high medical bills qualifies. The eligibility rules may be different for children, adults, and people in nursing facilities, but all people within a group are treated the same. In Virginia, the Department of Medical Assistance Services (DMAS) administers the Medicaid program. The Department of Social Services (DSS) has responsibility for taking applications and determining eligibility.

Medicaid has three levels of benefits:

- **Full coverage** – Provides the full range of benefits including doctor, hospital, and pharmacy services for those individuals not enrolled in Medicare.
- **Time-limited coverage** – Includes people who meet a spenddown or for women who receive 24 months of family planning services after their Medicaid coverage expires following a pregnancy.
- **Medicare-related coverage** – Provides Medicaid payment of Medicare premiums; may also include payment of Medicare's deductible and coinsurance, up to Medicaid's maximum payments.

### **How Do I Apply?**

To apply for Medicaid and FAMIS Plus, contact the Department of Social Services (DSS) in the city or county where you live. The phone number for your local DSS can be found in the blue pages of your phone book. Applications can also be filed at some larger hospitals. An application must be signed by the person who needs assistance unless it is completed and signed by the applicant's legal guardian, conservator, attorney-in-fact, or authorized representative. A parent, guardian, authorized adult representative, or caretaker relative with whom the child lives must sign applications for children under the age of 18. Children under the age of 18 cannot apply for themselves, unless they are emancipated. However, if a child under the age of 18 has a child of their own, they may file an application for the child. A face-to-face interview is not required.

You may use the screening tool on the DSS website (<http://dssiad.dss.state.va.us/EligibilityScreening>) to help determine whether you are eligible for Medicaid or children's health insurance, but the final decision must be made by an eligibility worker at your local DSS.

### **What Will I Be Asked?**

Applicants for Medicaid are asked to provide their Social Security number, declare Virginia residency, provide documentation of U.S. citizenship and identity or alien status. If you claim to be unable to work due to a disability, you will be asked whether you have applied for

disability benefits. If you have not, you may be asked further information about your medical condition. If you claim to be pregnant, you will be asked to provide proof of pregnancy from a medical provider, such as the written medical results (documentation) of your pregnancy test.

### **Income**

You must disclose all income that you receive. Income includes earned income, such as wages, as well as unearned income such as Social Security, retirement pensions, veteran's benefits, child support, etc. All sources of income are added together and compared to the income limit to determine eligibility.

The income limits vary according to the covered group and the type of coverage. For some groups, the income limits vary depending on the county or city where you live. Total "gross income" is evaluated; deductions are allowed according to Medicaid policy, and the amount of income remaining is compared to the appropriate Medicaid limit. "Gross income" is the amount before taxes or any deductions from the income are taken. The amount of your debts or bills that you owe is not used in determining whether your income is within the Medicaid limit.

People who meet all Medicaid eligibility requirements except for income may be placed on a "spenddown". This group is referred to as **Medically Needy**. An individual whose income is higher than the Medicaid income limit but is less than their medical expenses may be eligible for Medicaid for a limited period of time.

Children and pregnant women who have income over the Medicaid income limit may qualify for the Family Access to Medical Insurance Security (FAMIS) program, Virginia's Child Health Insurance Program. For more information, call FAMIS at 1-886-87FAMIS, (1-866-873-2647).

### **Resources (Assets)**

You may be required to disclose all resources that you own. There is no resource evaluation for FAMIS Plus and certain pregnant women. Resources include money on hand, in the bank, and in a safe deposit box; stocks, bonds, certificates of deposit, trusts, or pre-paid burial plans. Resources also include cars, boats, life insurance policies, and real property. **All resources must be reported**, however; not all resources are counted in deciding eligibility for Medicaid. For example, ownership of all vehicles must be reported, however; one vehicle that you own is not a countable resource for Medicaid purposes.

If the value of your resources is more than the Medicaid resource limit when you apply for Medicaid coverage, you may become eligible for Medicaid by reducing your resources to or below the limit. **A resource that is sold or given away for less than what it is worth may cause you to be found ineligible for Medicaid coverage of long-term care services for a certain period of time.**

### **Long-term Care (LTC) Asset Transfer**

If you need LTC services, either in a nursing facility or in your home, you will be asked to describe all transfers of assets (resources) that have occurred or trust funds that have been set up within the past five (5) years. This can include such actions as transferring the title to a vehicle, removing your name from a property deed, or giving away money. Medicaid applicants or enrollees who transfer (sell, give away, or dispose of) assets without receiving adequate compensation may be ineligible for Medicaid payment of long-term care services for

a period of time. Some asset transfers may not affect eligibility depending on the circumstances or if the Medicaid program determines that the denial of Medicaid eligibility would cause an undue hardship. Transfers occurring after enrollment in Medicaid may also result in a penalty for payment of your long-term care services.

### **Special Rules For Married Individuals Who Need Long Term Care**

Medicaid uses special rules to determine Medicaid eligibility when one member of a married couple receives long-term care and the other does not. These rules are referred to as “spousal impoverishment protections”. Resources and income are evaluated to determine how much may be reserved for the spouse who remains at home without affecting the Medicaid eligibility of the other spouse.

A resource assessment may be requested when a spouse is admitted to a medical institution. A resource assessment must be completed when a married institutionalized individual, who has a spouse in the community, applies for Medicaid.

Because the LTC policy is very complex, contact your local DSS if you have further questions. Local DSS staff will not advise an individual to take any specific course of action to achieve Medicaid eligibility, but they can provide you with detailed policy information.

### **Who Makes A Decision, And How Long Does It Take?**

Local DSS staff will determine whether you meet a Medicaid covered group (see section on Covered Groups) and if your resources and income are within required limits after they receive a signed application. The amount of income and resources you can have and still be eligible for Medicaid depends on how many people you have in your family and the limits established for your covered group.

An eligibility decision will be made on your Medicaid application: (1) within 45 calendar days, (2) within 90 calendar days if a disability decision is needed, or (3) within 10 working days of the agency’s receipt of the signed application if all necessary documentation has been provided to determine eligibility for pregnant women or women participating in the Virginia Department of Health’s Every Woman’s Life Program.

The local DSS will send you a written notice that your application has either been approved or denied. If you disagree with the decision made by the local DSS, you may file an appeal (see section on When and How to File and Appeal).

### **When Does Medicaid Start?**

Medicaid coverage usually starts on the first day of the month in which you apply and are found to be eligible. Medicaid coverage can start as early as three months before the month in which you applied if you meet all eligibility requirements and received a medical service during that time. Coverage under the Qualified Medicare Beneficiary (QMB) group always starts the month after the approval action. Spenddown coverage begins once the spenddown is met and continues until the end of the spenddown period. Contact your local DSS office if you have questions about when your Medicaid coverage starts.

### **How Do I Keep My Coverage?**

Once approved for Medicaid or FAMIS Plus, coverage will continue for 12 months, provided that the eligibility requirements continue to be met. Medicaid or FAMIS Plus coverage must be

reviewed annually (at least once every 12 months) to determine continued eligibility for the program. If this annual review is not completed, coverage will be canceled and you may have to pay for any medical care you or your child receives. In some cases your Medicaid or FAMIS Plus coverage may be reviewed before the end of the 12 months. When your annual review is due, your local DSS will send you a notice. You may be asked to complete a form and supply proof of your current income and some people may also have to provide proof of their current resources. Or, your eligibility may be reviewed for another 12 months using information already available to your DSS eligibility worker.

If you are notified to complete a form or send in proof of income or resources, it is very important that you do so immediately. If you do not provide the information by the deadline given, the Medicaid or FAMIS Plus coverage will be canceled. If you need assistance completing the forms, contact your eligibility worker.

If DSS is able to renew Medicaid or FAMIS Plus coverage with information they already have, you will receive a notice telling you the coverage has been continued and the date of your next annual renewal.

**REMEMBER** - You must report any change in circumstances within 10 calendar days of the change. If the reported change affects your eligibility for Medicaid or FAMIS Plus, your case will be reviewed at that time and you will be notified of the outcome. If you apply or are reviewed for another program provided by social services, such as Food Stamps or TANF, it is possible the eligibility worker will go ahead and renew your Medicaid/FAMIS Plus at the same time and extend your coverage for another 12 months from that date.

**IT IS VERY IMPORTANT** to tell your local DSS right away if you move or change your address. If they do not have a correct address, you will not receive a notice when it is time to renew Medicaid or FAMIS Plus coverage and your coverage will be canceled. If you move or change your address at any time, contact your local DSS right away to protect your coverage.

## **FULL COVERAGE GROUPS**

Federal and state laws describe the groups of people who may be eligible for Medicaid. These groups of people are called Medicaid covered groups. The eligibility rules and medical services available are different for certain covered groups. People who meet one of the covered groups may be eligible for Medicaid coverage if their income and resources are within the required limits of the covered group. The Medicaid covered groups are:

- Aged (65 and older), blind, or persons with disabilities:
  - with income up to 300% of the Supplemental Security Income (SSI) payment rate who have been screened and approved to receive services in a nursing facility or through one of the Medicaid Home-and-Community-Based Care Waivers;
  - who have income that does not exceed 80% of the Federal Poverty Income Guidelines\*;
  - Supplemental Security Income (SSI) enrollees who are age 65 or older, blind, or persons with disabilities and who meet Medicaid resource limits;
  - who lost SSI because their income or living situation changed.

- Auxiliary Grants (AG) enrollees in Assisted Living Facilities.
- Certain refugees for a limited time period.
- Children:
  - from birth to age 19 whose family income is at or below 133% of the Federal Poverty Income Guidelines\*; (Children from birth to age 19 whose family income is above 133% of the Federal Poverty Income Guidelines\* may qualify for FAMIS);
  - Children under age 21 who are in foster care or subsidized adoptions;
  - Infants born to Medicaid-eligible women.
- Low Income Families with Dependent Children (LIFC).
- Individuals who are blind or disabled, at least 16 years old but not 65 years of age, who are working or can work and earn income and whose income does not exceed 80% of the Federal Poverty Income Guidelines\*. Earned income and resources retained from earnings are disregarded up to a certain level once enrolled in the Medicaid Works program.
- Medically Needy individuals who meet Medicaid covered group requirements but have excess income.
- Individuals who are terminally ill and have elected to receive hospice care.
- Pregnant women (single or married) whose family income is at or below 133% of the Federal Poverty Income Guidelines\*; (Pregnant women whose family income exceeds 133% of the Federal Poverty Level may qualify for FAMIS MOMs.)
- Women screened by the Virginia Department of Health's Every Woman's Life Program who have been diagnosed and need treatment for breast or cervical cancer.

\*The Federal Poverty Income Guidelines are available on the DMAS website at:

<http://www.dmas.virginia.gov/rcp-home.htm>

## LIMITED COVERAGE GROUPS

### **Medicare-Related Covered Groups**

Individuals who are eligible for Medicare and who meet one of the following covered groups may receive limited Medicaid coverage. Medicaid pays the Medicare costs on behalf of these Medicare beneficiaries as indicated:

- **Qualified Medicare Beneficiaries (QMBs)** must be entitled to Medicare Part A. Income must be at or below 100% of the Federal Poverty Income Guidelines and resources must be at or below \$4,000 for a single person and \$6,000 for a couple. Medicaid pays the Medicare Part A and Part B premiums and the coinsurance and deductibles that Medicare does not pay.
- **Special Low-Income Medicare Beneficiaries (SLMBs)** must be entitled to Medicare Part A. Income must be between 100% and 120% of the Federal Poverty Income Guidelines and resources must be at or below \$4,000 for a single individual and \$6,000 for a couple. Medicaid pays the Medicare Part B premiums.

- **Qualified Individuals (QI)** must be entitled to Medicare Part A. Income must equal or exceed 120% but be less than 135% of the Federal Poverty Income Guidelines and resources must be at or below \$4,000 for a single person and \$6,000 for a couple. Medicaid pays the Medicare Part B premiums.
- **Qualified Disabled and Working Individuals (QDWIs)**—Medicaid can pay Medicare Part A premiums for certain disabled individuals who lose Medicare coverage because of work. These individuals must have income below 200% of the federal poverty income guidelines and resources must be at or below \$4,000 for a single person and \$6,000 for a couple.

### **Family Planning Services Program**

Women who receive Medicaid-paid pregnancy-related services and whose income is less than or equal to 133% of the federal poverty level are eligible to receive family planning services for up to 24 months from the end of the pregnancy. Coverage is limited to the following services: annual gynecological exams, family planning education and counseling, FDA approved contraceptives, including over-the-counter and prescription contraceptives, sexually transmitted infection screening at the initial family planning visit, and sterilization (not including hysterectomy).

Any family planning services enrollee needing other health services not covered by the family planning services program will be referred to the Virginia Primary Care Association, the local Health Department, and/or the Virginia Association of Free Clinics to obtain primary or routine medical care services if they are not otherwise eligible for Medicaid after pregnancy. Primary care services are the responsibility of the family planning services enrollee, who may be charged a reduced rate or a sliding scale fee for such services. Women who have had tubal ligations or hysterectomies are not eligible to receive family planning services.

### **Emergency Services for NonCitizens**

Special rules apply to non-citizens. If a person meets one of the covered groups listed above but is not a U.S. citizen, then his immigration status and date of entry into the U.S. determine his eligibility for full Medicaid coverage. If the immigration status prohibits full Medicaid coverage, he may be eligible for emergency medical treatment provided he meets all other Medicaid eligibility requirements.

## **MEDICAID AND OTHER INSURANCE**

You can have private health insurance and still be covered by Medicaid or FAMIS Plus. If you have other insurance, the other insurance plan pays first. Having other health insurance does not change the Medicaid co-payment amount, if one is required, that you will pay to providers as a Medicaid enrollee. If you have a Medicare supplemental policy, you can suspend your policy for up to 24 months while you have Medicaid without penalty from your insurance company. You must notify the insurance company within 90 days of the end of your Medicaid coverage to reinstate your supplemental insurance. If you drop private health insurance coverage or you enroll in a private health insurance plan, tell your eligibility worker at DSS, otherwise, payment of your bills could be delayed.

When Medicaid has paid claims for covered services and it is later found that another payment source was available, Medicaid will try to recover the money from the other source, whether it

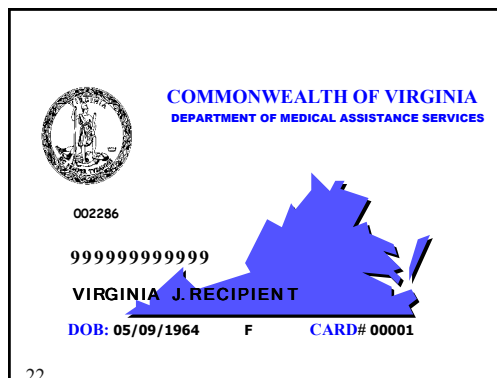
is commercial insurance, Medicare, Worker's Compensation, or liability insurance (if the claim is for an accident). Applicants for Medicaid sign a statement called "Assignment of Rights to Medical Support and Third-Party Payments." If you are paid by your insurance company after Medicaid has paid the same bill, you must send that money to DMAS.

### **Health Insurance Premium Payments (HIPP)**

Medicaid may help with the cost of private health insurance premiums when it is cost-effective for the program. The HIPP Program only reimburses for employer sponsored group health plans; it does not reimburse premiums for individual policies. DSS is responsible for providing information regarding this program. You may get further information by calling the Health Insurance Premium Payment Program (HIPP) at 1-800-432-5924.

## **MEDICAID OR FAMIS PLUS MEDICAL CARD**

When you are found eligible, you will be mailed a blue and white plastic medical assistance card (Medicaid or FAMIS Plus card), which contains your name and identification number. **It is your responsibility to show your Medical Card to providers at the time you go for services and to be sure the provider accepts payment from Virginia Medicaid.** If you have a Medicaid or FAMIS Plus card because you were eligible at an earlier time, that card will be valid again when your coverage is reinstated.



### **Using Your Medical Card**

You will get a plastic medical identification card in the mail when you are approved for Medicaid or FAMIS Plus (unless you are only eligible for payment of your Medicare premiums). Every person in your family who is eligible for Medicaid or FAMIS Plus gets his or her own card. You will **not** receive a new card if your benefits change. You can request a replacement card from the local DSS if your card is lost, stolen or destroyed.

Show your card(s) **each time you get a medical service** so that your medical provider can verify your current eligibility status. If you are enrolled in a Managed Care Organization (MCO), you will get a separate card from that organization. **You need to show both the MCO and the medical card when you get care.** If you do not take your card(s), you may be treated as a private-paying patient and you will be responsible for paying the bill.

**It is your responsibility to show your medical identification card to providers at the time you go for service and to be sure the provider accepts payment from Virginia Medicaid or from your assigned MCO, if appropriate.** Report the loss or theft of your medical identification card to the local DSS or your MCO card to your MCO right away.

## USING YOUR MEDICAID BENEFITS

### Regular Medicaid Coverage

Providers who are directly enrolled with DMAS offer care directly to some Medicaid/FAMIS Plus enrollees, this is referred to as Fee-For-Service (FFS). If you do not have an assigned doctor or MCO (Managed Care Organization), you can choose any provider of care for medical services as long as the provider accepts Virginia Medicaid payments. If you receive services from providers who are not enrolled in Virginia Medicaid, **you will have to pay the bill. Medicaid will not pay you back for the medical bills that you have paid.** Try to use one doctor and one pharmacy for most of your care, and continue with that doctor unless you are referred to a specialist.

### Managed Care

Most Virginia Medicaid and FAMIS Plus enrollees are required to receive their medical care through managed care programs. Virginia has two managed care programs established to provide quality health care services to enrollees – MEDALLION and MCO (Managed Care Organization) programs. If you meet the criteria to be assigned to a managed care program, within 15-45 days after your Medicaid approval you will receive a letter from DMAS requiring you to choose either a MEDALLION Primary Care Provider (PCP) or an MCO for your health care. You will receive helpful information about the programs such as a list of MEDALLION PCPs and a Help Sheet, or an MCO Comparison Chart and a brochure. You will have approximately one month to choose a MEDALLION PCP or an MCO. **If you do not make a choice, you will be assigned to a PCP or MCO.**

#### MEDALLION

In MEDALLION, you will be assigned to a PCP who will provide primary health care services, give you referrals to other health care providers when needed, and coordinate your healthcare needs. You can choose a different PCP for each person in your family who is covered by MEDALLION. Ask your family doctor if they accept MEDALLION. Your Primary Care Provider will be identified on a letter introducing your MEDALLION enrollment. Call the DMAS Managed Care Helpline at 1-800-643-2273 for more information.

#### Managed Care Organizations (MCOs)

An MCO is a health service organization that coordinates health care services through a network of providers that includes PCPs, specialists, hospitals, clinics, medical supply companies, transportation service providers, drug stores, and other medical service providers. DMAS contracts with 5 MCO plans, AMERIGROUP, Anthem, CareNet, Optima Family Care, and Virginia Premier. Once you select the MCO of your choice, the MCO will mail a packet of information directly to you. You also will receive an MCO identification card to use with your plastic medical ID card. **Please keep both cards with you and present both cards each time medical care is received.** The MCO will require you to choose a PCP in their network who will manage all of your health care needs. You are not required to enroll all members of your family in the same MCO or with the same PCP.

You will be required to follow managed care program rules. These rules are described in the MCO member handbook, which is included in the information packet that your MCO will send to you. If you do not follow the managed care program rules (for example, if you receive

services without obtaining a referral from your PCP or an authorization from your MCO), you may have to pay the bill as a private-paying patient. Refer to your MCO member handbook for more details. Call the DMAS Managed Care Helpline at 1-800-643-2273 for information.

#### Open Enrollment

There is an annual open enrollment period for the MEDALLION and MCO programs. This open enrollment period allows you to change your MEDALLION PCP or your MCO. If you want to know when your open enrollment period takes place or have other questions regarding your managed care enrollment, call the DMAS Managed Care Helpline at 1-800-643-2273.

#### Client Medical Management (CMM)

Some people need special management of their doctor and pharmacy use. If you are identified for enrollment in Client Medical Management (CMM), you will receive a letter from the DMAS Recipient Monitoring Unit (RMU). You will have the opportunity to choose your PCP and pharmacy within 30 days of receiving the enrollment notice. **If you do not notify Medicaid of your choices, providers will be selected for you.** Once you are assigned to one doctor and/or pharmacy, you must get your care only from them unless they refer you to another provider. Your PCP must give you a written referral form when you need to see a specialist. You may only use another pharmacy in an emergency as defined by CMM rules. Your plastic card contains information like a credit card, which tells the provider the names of your CMM providers. Each CMM enrollee is assigned a case manager to answer questions about the program and assist you in following the program rules.

### **MEDICAL CARE UNDER MEDICAID AND FAMIS PLUS**

Most medical care, both inpatient and outpatient, is covered by Medicaid. There are certain limits and rules that apply. For example, some medical procedures must be performed as outpatient surgery unless there is a medical need for hospital admission. Care in an institution for the treatment of mental diseases is not covered for people between the ages of 21-64. Routine dental care for adults is not covered. There are limits to the number of visits approved for home health, psychiatric services, and other professional services. Some services require prior authorization. For more information about services covered under Medicaid and FAMIS Plus, contact the DMAS Recipient Helpline at (804) 786-6145.

#### **BabyCare - Maternal and Child Health**

BabyCare is a program for pregnant women and infants who are receiving services through FAMIS, FAMIS Plus, FAMIS MOMS or Medicaid and who are not currently enrolled in a Managed Care Organization (MCO). Women and infants enrolled in an MCO should contact their MCO for information on pregnancy and infant programs. BabyCare Case Management Services are for pregnant women or infants up to age two who are at higher risk for problems during pregnancy or early childhood. BabyCare Expanded Services for pregnant women include childbirth and parenting classes, nutrition services, homemaker services for women on bed rest, and substance abuse treatment services.

#### **Dental Care (Smiles for Children)**

The *Smiles For Children* program provides coverage for diagnostic, preventive, restorative/surgical procedures, as well as orthodontia services for Medicaid and FAMIS Plus children. The program also provides coverage for limited medically necessary oral surgery

services for adults (age 21 and older). Doral Dental USA coordinates the delivery of all *Smiles For Children* dental services. If you need help finding a dentist or making a dental appointment, please call 1-888-912-3456 to speak with a *Smiles For Children* representative. Information is also available on the DMAS website at <http://www.dmas.virginia.gov/dental-home.htm>.

### **Healthy Returns Disease State Management Program**

A program designed to help patients better understand and manage coronary artery disease, congestive heart failure, asthma, chronic obstructive pulmonary disease (COPD), and diabetes through prevention, education, lifestyle changes, and adherence to prescribed plans of care. *Healthy Returns* is offered to all fee-for-service Medicaid and FAMIS enrollees identified as having any of the covered chronic conditions with the exception of individuals enrolled in Medicare (dual eligible); individuals who live in institutional settings (such as nursing facilities); and individuals who have third party insurance. If you have one of these conditions, call *Healthy Returns* at 1-800-836-4008 for more information.

### **Inpatient Hospital Admissions**

The admitting doctor must call for pre-authorization before you are admitted, or within 24 hours after an emergency admission.

### **Medical Professional Visits**

Psychiatric, nursing, physical therapy, occupational therapy, and speech therapy visits have to be approved after a certain number of visits have occurred, if additional visits are needed.

### **Pharmacy**

Your doctor may have to get pre-authorization in order for a pharmacy to fill some prescription drugs. Within a family of drugs, there may be one or a few select drugs that Medicaid would like your doctor to use to treat your condition because they are safe, effective, and less costly. This is called a Preferred Drug List (PDL). You can still receive medication to effectively treat your medical condition. Prior approval is required to fill the prescription if the drug is not on the PDL. A doctor may also prescribe or order some over-the-counter drugs equivalent to certain prescription drugs if it is cost effective to do so. When available, generic drugs are dispensed unless the doctor specifies that a particular brand name is medically necessary. This is true whether you get services directly through Medicaid or through an MCO. If you have questions about the PDL, call First Health at 1-800-932-3923, your MCO, or talk to your doctor.

Enrollees who have Medicare Part A or Part B coverage must receive prescription drug coverage under Medicare Part D. Virginia Medicaid will not pay for prescription drugs that are covered under Medicare Part D for Medicare-eligible enrollees. For information about coverage under Medicare Part D contact Medicare at 1-800-MEDICARE (800-633-4227).

### **Transportation**

Transportation services are provided when necessary to help people access Medicaid covered services. Medicaid covers two types of transportation:

- **Emergency** - Medicaid pays for emergency transportation to receive medical treatment.
- **Non-Emergency** – All non-emergency medical transportation is provided through a transportation broker or through your Managed Care Organization.

Transportation is provided if you have no other means of transportation, and need to go to a physician or a health care facility. Your medical condition should not be life threatening. In case of a life-threatening emergency, call 911. Call the reservation line at 1-866-386-8331 at least 48 hours (2 days) prior to the scheduled medical appointment. (Verifiable urgent trips, like hospital discharges, may be accepted with less than 48 hours notice.) Please have your Medicaid ID number available when you call. Enrollees in an MCO should call the transportation number listed in your handbook to arrange for non-emergency trips.

**Remember:** Trips must be for a Medicaid covered service and medically necessary. Examples: doctor appointment, counseling, dialysis, dental appointment.

### **Out-of-State Medical Coverage**

Virginia Medicaid will cover emergency medical services you receive while temporarily outside of Virginia if the provider of care agrees to participate in Virginia's Medicaid Program and to bill Medicaid. **No payments are made directly to enrollees for service costs incurred out of state.** Rules for out-of-state care may be different if your coverage is through an MCO. If you are enrolled in an MCO, contact them for their procedures regarding out-of-state treatment.

If you receive emergency medical services out of state from a provider not enrolled in Virginia Medicaid, tell the out-of-state provider to contact the DMAS Provider Enrollment Unit at:

First Health Provider Enrollment Unit  
P.O. Box 26803  
Richmond, Virginia 23261  
Phone: 1-888-829-5373

**Virginia Medicaid does not cover medical care received outside of the United States.**

## **CO-PAYMENTS**

Some Medicaid enrollees must pay a small amount for certain services. This is called a co-payment.

The following enrollees do not pay a co-payment for services covered by Medicaid:

- People younger than age 21;
- People receiving institutional or community-based care, long-term care services (patient pay may be applicable); and
- People in hospice programs.

Medicaid does not charge a co-payment for the following services:

- Emergency services (including dialysis treatments);
- Pregnancy-related services;
- Family-planning services; and
- Emergency room services.

Medicaid charges co-payments for enrollees age 21 and older for the following services:

Service	Co-Payment Amount
Inpatient hospital	\$ 100.00 per admission
Outpatient hospital clinic	3.00 per visit
Clinic visit	1.00 per visit
Physician office visit	1.00 per visit
Other physician visit	3.00 per visit
Eye examination	1.00 per examination
Prescription	1.00 for generic 3.00 for brand name
Home health visit	3.00 per visit
Rehabilitation service	3.00 per visit

A medical provider cannot refuse to treat you or provide medical care if you are not able to pay the co-payment. However, you are still responsible for paying the co-payment.

## **BENEFITS UNDER MEDICAID AND FAMIS PLUS**

A description of the benefit is provided following this list.

- Clinic Services
- Community-Based Residential Services for Children and Adolescents under 21- Level A
- Community Mental Health and Mental Retardation Services
- Dental Care Services
- Durable Medical Equipment and Supplies (DME)
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) – most frequently provided specialized services are:
  - Hearing Aids
  - Medical Formula and Medical Nutritional Supplements
  - Personal Care
  - Private Duty/Specialized Nursing
  - Specialized Services to Address Complex Medical Needs
  - Substance Abuse Treatment
- Eye Examinations
- Eyeglasses
- Family Planning Services
- Glucose Test Strips
- Home Health Services
- Hospice Services
- Hospital Care – Inpatient/Outpatient
- Hospital Emergency Room
- Inpatient Psychiatric Hospital Services for Individuals 65 or Older
- Lead Testing

- Long-Term Care
- Maternal and Infant Care Coordination (BabyCare)
- Nursing Facility
- Organ Transplants
- Personal Care
- Physician's Services
- Podiatry Services (foot care)
- Prenatal Care Expanded Services (Babycare)
- Prescription Drugs when ordered by a Physician
- Prosthetic Devices
- Psychiatric or Psychological Services
- Renal (Kidney) Dialysis Clinic Visits
- Rehabilitation Services
- Residential Treatment Services (Level C)
- Substance Abuse (Effective 7/1/07)
- Therapeutic Behavioral Services (Level B)
- Transportation Services for Medical Treatment:
- Treatment Foster Care – Case Management

### **Covered Services Description**

**Clinic Services** - Facility (public and private) for the diagnosis and treatment of persons receiving outpatient care.

**Community-Based Residential Services for Children and Adolescents under 21 - Level A-** Community Based Residential Services for Children and Adolescents under 21 are a combination of therapeutic services rendered in a residential setting. The residential service will provide structure of daily activities, psycho-education, therapeutic supervision, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). The child/adolescent must also receive psychotherapy services in addition to the therapeutic residential services. Room and board costs are not included in the reimbursement for this service. Only programs/facilities with 16 or fewer beds are eligible to provide this service.

**Community Mental Health and Mental Retardation Services** – Services provided in the individual's home or community that provide diagnosis, treatment, or care of persons with mental illnesses or mental retardation. These services are provided primarily by Community Services Boards and private providers.

**Dental Care Services** – Routine services are available only for children under age 21. Dentures, braces, and permanent crowns for children are covered when prescribed by a dentist and pre-authorized by DMAS. Adult coverage is limited to emergencies only.

**Durable Medical Equipment and Supplies (DME)** – Medically necessary medical equipment and supplies may be covered when they are necessary to carry out a treatment prescribed by a physician. For example:

- Ostomy supplies;
- Oxygen and respiratory equipment and supplies;
- Home dialysis equipment and supplies

**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)** – A program of preventive health care and well child examinations with appropriate tests and immunizations for children and teens from birth up to age 21 to keep children healthy. Medically necessary services, which are required to correct or ameliorate defects and physical or mental illnesses that are discovered during a screening examination, may be covered as a part of the EPSDT program even if they are not covered under the State's Medical benefit plan. (See Section "SERVICES FOR CHILDREN/EPSDT").

**Eye Examinations** – Limited to once every two years.

**Eyeglasses** – Covered only for enrollees younger than 21 years of age.

**Family Planning Services/Birth Control** – Services that delay or prevent pregnancy including diagnosis, treatment, drugs, supplies, devices and certain elective sterilization procedures (for women). Coverage of such services does not include services to treat infertility or services to promote fertility.

**Glucose Test Strips** – Blood glucose self-monitoring test strips when medically necessary.

**Home Health Services** – Visits by a nurse, physical therapist, occupational therapist, or speech and language therapist requires prior approval after five visits. The visits of a home health aide are limited to 32 visits annually.

**Hospice Services** – Medically-directed program providing a continuum of home, outpatient, and homelike inpatient care for the terminally ill. (Terminally ill is defined as having a medical prognosis that life expectancy is six months or less).

**Hospital Care -**

- **Inpatient** - A patient who has been admitted to a hospital for bed occupancy to receive hospital services. Approved days are covered.
- **Outpatient** – A patient receiving medical services but not admitted to a hospital.

**Hospital Emergency Room** – Visits are covered for emergencies, when you have a serious medical problem that cannot wait and your life or health is in immediate danger.

**Inpatient Psychiatric Hospital Services for Individuals 65 Years of Age or Older** – Services that provide diagnosis, treatment, or care of persons with mental illnesses. This includes medical attention, nursing care, and related services. These services are provided in institutional settings called "Institutions for Mental Disease," which can be hospitals, nursing facilities, or other institutions of more than 16 beds.

**Lead Testing** – This test is required for every Medicaid-eligible child as part of the 12- and 24-month EPSDT screenings. It is also administered on any child between the ages of 36 and 72 months old who has not been previously screened.

**Long-Term Care** – This may include care in an institutional setting such as: a Nursing Facility or Intermediate Care Facility for the Mentally Retarded or in the community through a Home-and-Community-Based Services Waiver.

**Maternal and Infant Care Coordination (MICC)** – Case management services provided through BabyCare for high risk pregnant women and infants up to age 2 enrolled in Medicaid.

**Nursing Facility** – A licensed and certified facility, which provides services to individuals who do not require the degree of care and treatment, which a hospital provides.

**Organ Transplants** – Kidney, liver, heart, lung, cornea, high-dose chemotherapy, and bone marrow/stem cell transplantation are covered. All transplants except corneas require pre-authorization.

**Personal Care** – Support services provided in the home and community setting for enrollees under the age of 21 under EPSDT who meet established medical necessity criteria to assist with activities of daily living (basic daily tasks of bathing, dressing, toileting, transferring, eating, bowel and bladder continence necessary to maintain health and safety), monitoring of self-administrated medications, and the monitoring of health status and physical condition. Services will not take the place of informal support systems.

**Physician's Services** – General Practitioner, Specialists, and Osteopaths.

**Podiatry Services (foot care)** – Routine and preventive foot care is not covered. Payment for the trimming of the nails for a medical condition such as diabetes is limited to once every 2 months.

**Prenatal Care Expanded Services** – Expanded prenatal services provided through BabyCare are available to any pregnant woman enrolled in Medicaid, regardless of enrollment in MICC, to assist in a positive pregnancy outcome. These services are:

- Prenatal education in smoking cessation, preparation for childbirth, and parenting;
- Nutritional assessment and counseling; and
- Homemaker services to clients for whom the physician has ordered complete bed rest.

A risk screen on the client must be completed by an approved provider to identify necessity, type of service and also serves as the referral tool.

**Prescription Drugs when ordered by a Physician** – Medicaid has a preferred drug list (PDL), but drugs not on the list can be covered if pre-authorized. Prescriptions are filled with no more than a 34-day supply at a time. When available, generic drugs are dispensed unless the doctor specifies that a particular brand name is medically necessary. Some over-the-counter drugs can be covered if ordered by a doctor instead of a prescription drug. **Medicaid enrollees who have Medicare coverage must receive their prescription drug coverage under Medicare Part D.** For information about coverage under Medicare Part D, call 1-800-MEDICARE, (1-800-633-4227).

**Prosthetic Devices** – Limited to artificial arms, legs, and the items necessary for attaching the prostheses; must be preauthorized by DMAS.

**Psychiatric or Psychological Services** – Medicaid requires preauthorization of all visits after the first 26 sessions. No more than 26 additional sessions per year will be pre-authorized.

**Renal (Kidney) Dialysis Clinic Visits** – Outpatient visits for dialysis treatment of end-stage renal disease. The visit may have two components, the outpatient facility and the physician evaluation and management fees.

**Rehabilitation Services** – Outpatient services for physical therapy, occupational therapy, and speech-language pathology.

**Residential Treatment Services (Level C)** – Freestanding Hospital and Residential Treatment Facility Services for Children and Adolescents under Age 21 whose need for services is identified through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Services must be medically necessary and preauthorization is required.

**Substance Abuse Treatment (Effective 7/1/2007)** – Outpatient services, crisis intervention, assessment and evaluation, and case management services.

**Therapeutic Behavioral Services (Level B)** – Community-Based Residential Services for Children and Adolescents under 21 are a combination of therapeutic services rendered in a residential setting. These services will provide structure for daily activities, psycho-education, therapeutic supervision, and psychiatric treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan (plan of care). The child/adolescent must also receive psychotherapy services in addition to the therapeutic residential services. Room and board costs are not included in the reimbursement for this service. Only programs or facilities with 16 or fewer beds are eligible to provide this service.

**Transportation Services for Medical Treatment:**

- **Emergency** – Medicaid pays for emergency transportation to receive medical treatment.
- **Non-Emergency** – Non-emergency medical transportation is arranged through a transportation broker or through your MCO. Not all Medicaid enrollees get transportation services. If you do not have a car or a family member that can transport you to a Medicaid-covered service appointment, and you are not enrolled in an MCO, call for assistance toll-free at 1-866-386-8331.

**Treatment Foster Care – Case Management** – Case Management Services for children who are in treatment foster care.

## **SERVICES FOR CHILDREN/EPSDT**

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a comprehensive and preventive child health program for enrollees in Medicaid or FAMIS Plus up to the age of 21 that detects and treats health care problems early through:

- ✓ Regular medical, dental, vision, and hearing check-ups
- ✓ Diagnosis of problems
- ✓ Treatment of dental, eye, hearing, and other medical problems discovered during check-ups

**EPSDT IS FREE:**

- ✓ Medicaid will pay for the EPSDT check-ups.
- ✓ Medicaid will pay for the treatment of dental, vision, hearing, and other medical problems, found during a check-up.
- ✓ Medicaid will provide transportation to your child's appointment. Contact your Managed Care Organization or if you do not have a Managed Care Organization call toll-free: (866) 386-8331.

**EPSDT exams (check-ups) are done by your child's doctor and must include:**

- ✓ A complete history of your child's health, nutrition, and development
- ✓ A head-to-toe physical exam
- ✓ Health education
- ✓ A growth and development check
- ✓ Lab tests
- ✓ All children must be tested for lead exposure at 12 and 24 months of age or before the age of 6 if not previously tested
- ✓ Shots/immunizations, as needed
- ✓ Eye check-up
- ✓ Hearing check-up
- ✓ Referral to a dentist by the age of three

\*Dental check-ups with a dentist should be done every 6 months. For a referral to a dentist contact *Smiles For Children* at 1-888-912-3456.

**You should visit your child's doctor for check-ups early and on a regular basis.**

If your child's doctor finds a health problem during an EPSDT check-up, he may be able to treat the problem or may send you to another provider (specialist) who can treat it.

**Getting regular EPSDT Check-Ups even when your child is not sick is the best way to make sure your child stays healthy!**

Use the chart below to find out when your child should receive regular check-ups:

<b>Babies need check-ups at:</b>	<b>Toddlers &amp; Children need check-ups at:</b>	<b>Older Children need check-ups at:</b>	<b>Teenagers need check-ups at:</b>
1 month * 2 months * 4 months * 6 months * 9 months * 12 months *	15 months * 18 months * 2 years * 3 years 4 years *	5 years * 6 years * 8 years 10 years	12 years * 14 years 16 years 18 years 20 years

\* Most immunizations (shots) are given during these visits

**<<<<<<Ask your doctor for more information about immunizations>>>>>>**

***If a treatment or service is needed to correct, improve a problem that is found during an EPSDT check-up, or prevent a problem from getting worse, talk with your child's doctor. There are services covered through EPSDT that are not normally covered by Medicaid. Your child may be referred for medically necessary specialty care or other health services if the PCP or screening provider is not able to provide the treatment.***

## **WHAT IS NOT COVERED BY MEDICAID AND FAMIS PLUS**

- Abortions, unless the pregnancy is life-threatening or health-threatening;
- Acupuncture;
- Administrative expenses, such as completion of forms and copying records;
- Alcohol and drug abuse therapy (except as provided through EPSDT or for pregnant women through the Community Services Boards and under the BabyCare program);
- Artificial insemination, in-vitro fertilization, or other services to promote fertility;
- Broken appointments;
- Certain drugs not proven effective and those offered by non-participating manufacturers (enrolled doctors, drugstores, and health departments have lists of these drugs);
- Certain experimental surgical and diagnostic procedures;
- Chiropractic services (except as provided through EPSDT);
- Cosmetic treatment or surgery;
- Daycare, including sitter services for the elderly (except in some home- and community-based service waivers);
- Dentures for enrollees age 21 and over;
- Doctor services during non-covered hospital days;
- Drugs prescribed to treat hair loss or to bleach skin;
- Eyeglasses or their repair for enrollees age 21 or older;
- Friday or Saturday hospital admission for non-emergency reasons or admission for more than one day prior to surgery unless the admission on those days is pre-authorized;
- Hospital charges for days of care not authorized for coverage;
- Immunizations if you are age 21 or older (except for flu and pneumonia for those at risk);
- Inpatient hospital care in an institution for the treatment of mental disease for enrollees under age 65 (unless they are under age 22 and receiving inpatient psychiatric services);
- Medical care received from providers who are not enrolled in or will not accept Virginia Medicaid;
- Personal care services (except in some home and community-based service waivers or under EPSDT);
- Prescription drugs if the enrollee has coverage under Medicare Part A or Part B

- Private duty nursing (except in some home and community-based service waivers or under EPSDT);
- Psychological testing done for school purposes, educational diagnosis, school, or institution admission and/or placement or upon court order;
- Remedial education;
- Routine dental care if you are age 21 or older;
- Routine school physicals or sports physicals;
- Sterilization of enrollees younger than age 21;
- Telephone consultation; and
- Weight loss clinic programs.

Some services above may be covered for enrollees under age 21 under EPSDT. EPSDT can provide special health care to your child when medically necessary. Under EPSDT, Medicaid may provide certain services to children that are not covered for adults.

Once you are found eligible, if you receive a service not covered by Medicaid or you receive more services than the Medicaid limit for that service, you will have to pay those bills.

## **LONG-TERM CARE (LTC) SERVICES**

Medicaid pays for LTC services in some institutional settings, such as nursing facilities and Intermediate Care Facilities for the Mentally Retarded and for individuals in their communities through Home-and-Community-Based-Care Waivers. To qualify for LTC services, an individual must meet certain level-of-care requirements. These requirements may include assistance with activities of daily living and/or a medical nursing need. There are different eligibility rules and requirements such as: pre-admission screening, asset transfer, and patient pay, which only apply to individuals who need Medicaid coverage for long-term care services. Contact your local DSS for details if Medicaid long-term care services are needed.

### **Screening for Long-Term Care Services**

A screening is required to determine whether an individual meets the level-of-care criteria for long-term care services. Screening is not required if the person is already in a nursing facility or is entering the facility directly from another state. Screenings for institutional and community-based long term care are completed by the following teams:

- Local teams composed of health and social service agencies;
- Staff of acute care hospitals;
- Community Services Boards; and/or
- Child Development Clinics.

### **Home and Community-Based Waivers**

Virginia provides a variety of services under home and community-based waivers to specifically targeted individuals, such as personal care. Each waiver provides specialized services to help certain individuals to remain in their communities. The seven waivers available are:

- AIDS Waiver - provides care in the community rather than in a hospital or nursing facility for individuals who are experiencing medical and functional symptoms associated with HIV/AIDS.
- Elderly or Disabled with Consumer Direction (ED/CD) Waiver - provides care in the community rather than in a nursing facility for individuals who are elderly or have a disability. Individuals may choose to receive agency-directed services, consumer-directed services or a combination of the two as long as it is appropriate and duplicate services are not provided. Services offered in this waiver include personal assistance, respite (including skilled respite), adult day health care, and personal emergency response system services.
- Individual and Family Developmental Disabilities (DD) Support Waiver - provides care in the community rather than in an Intermediate Care Facility (for persons with) Mental Retardation (ICF/MR) for individuals 6 years of age and older with a condition related to mental retardation, but who do not have a diagnosis of mental retardation, and who (1) meet the ICF/MR level of care criteria (i.e., they meet two out of seven levels of functioning in order to qualify), (2) are determined to be at imminent risk of ICF/MR placement, and (3) are determined that community-based care services under the waiver are the critical services that enable the individual to remain at home rather than being placed in an ICF/MR.
- Mental Retardation (MR) Waiver - provides care in the community rather than in an Intermediate Care Facility (for persons with)/Mental Retardation (ICF/MR) for individuals who are up to 6 years of age who are at developmental risk and individuals age 6 and older who have mental retardation. Services available under this waiver include, residential support, day support, supported employment, prevocational services, personal assistance, respite, companion, assistive technology, environmental modifications, skilled nursing services, therapeutic consultation, crisis stabilization, personal emergency response systems.
- Technology Assisted (Tech) Waiver - provides care in the community rather than in a nursing facility for individuals who are dependent upon technological support and require substantial, ongoing nursing care. Services available under this waiver include personal care (adults only), private duty nursing, respite care, environmental modifications and assistive technology.
- Day Support (DS) Waiver for Individuals with Mental Retardation – provides home and community-based services to individuals with mental retardation who have been determined to require the level of care provided in an ICF/MR and are on the waiting list for the MR Waiver. The services provided under this waiver include, day support and prevocational services.
- Alzheimer's Assisted Living (AAL) Waiver – is available only to individuals who are Auxiliary Grants (AG) recipients, have a diagnosis of Alzheimer's disease or a related dementia and no diagnosis of mental illness or mental retardation. The services provided under this waiver include, assistance with activities of daily living, medication administration by licensed professionals, nursing services for assessments and evaluations and

therapeutic social and recreational programming which provides daily activities of individuals with dementia.

Please contact your local Department of Social Services, Community Services Boards, or DMAS for further information.

## YOUR RIGHTS AND RESPONSIBILITIES

### You have the right to ...

- file an application for assistance.
- receive written information about specific eligibility policies.
- have a decision made promptly.
- receive a written notice of the decision.
- have your personal and health information kept private.
- have advance notice of actions that end or reduce your coverage.
- appeal any action, such as:
  - any decision denying, terminating or reducing Medicaid eligibility;
  - any unreasonable period of time taken to decide if you are eligible; or,
  - any decision denying, terminating or reducing Medicaid-covered medical services.

### You have the responsibility to...

- complete the application and renewal forms fully and accurately.
- supply requested information, or to advise of any problems you are having in getting the necessary information.
- inform your eligibility worker of any other medical insurance that may cover some of your bills.
- **immediately report** changes in your circumstances to the local department of social services such as:
  - moving, birth or death of a child, marriage, new employment, adding or dropping other insurance.
  - the early termination or loss of pregnancy
  - changes in your financial condition (which includes both earned and unearned income such as Social Security, SSI, going to work, changes in employment, transfers of assets or inheriting). Any medical insurance that may cover some of your bills.
  - filing a personal injury claim due to an accident.
- keep scheduled appointments.
- show your medical provider proof of your coverage when you go for care.

## **FRAUD AND OTHER RECOVERIES**

Medicaid fraud is a deliberate withholding or hiding of information or giving false information to get Medicaid or FAMIS Plus benefits. Medicaid fraud also occurs when a provider bills Medicaid for services that were not delivered to a Medicaid recipient, or if a recipient shares his/her Medicaid number with another person to get medical care.

Anyone convicted of Medicaid fraud in a criminal court must repay the Medicaid program for all losses (paid claims and managed care premiums) and cannot get Medicaid for one year after conviction. In addition, the sentence could include a fine up to \$25,000 and/or up to 20 years in prison. You may also have to repay the Medicaid program for any claims and managed care premiums paid during periods you were not eligible for Medicaid due to acts not considered criminal. Fraud and abuse should be reported to your local Department of Social Services or to the Department of Medical Assistance Services Recipient Audit Unit at (804) 786-0156.

Medicaid can also recover expenditures made for services received by, or managed care premiums paid on behalf of, ineligible enrollees who did not intend to defraud. This also includes recovery for medical services received during an appeal process where the agency's action is upheld. There is no time limit (statute of limitations) for Medicaid recoveries.

If you are enrolled in a Medicaid MCO, premiums are paid by Medicaid to the MCO every month to ensure your coverage, even if you do not utilize medical services. These premiums are considered losses to the program and can be recovered if you are determined ineligible for any prior period. If you are found to be ineligible for prior months of coverage due to your failure to report truthful information or changes in your circumstances to your caseworker, you may be liable to repay these monthly premiums.

### **Third Party Liability and Personal Injury Claims**

If you have been injured in any type of accident and have a personal injury claim, you must inform your eligibility worker at DSS so that Medicaid may recover payment from the person responsible for the accident. DSS will need information such as the date of the accident/injury, type of accident and the name of the attorney or insurance company, if any.

### **Estate Recovery**

Report the death of a Medicaid enrollee to your local DSS office. Medicaid can recover money from the estate of a Medicaid enrollee over age 55. Recovery may take place only after the death of any surviving spouse and only if there are no minor or disabled children.

## **WHEN AND HOW TO FILE AN APPEAL**

You have the right to request an appeal of any adverse action related to initial or continued eligibility for Medicaid or FAMIS Plus. This includes delayed processing of your application, actions to deny your request for medical services, or actions to reduce or terminate coverage after your eligibility has been determined. Even if you are enrolled in an MCO you can appeal directly to DMAS.

To request an appeal, notify DMAS in writing of the action you disagree with within 30 days of receipt of the agency's notice about the action. You may write a letter or complete an Appeal Request Form. Forms are available on the Internet at [www.dmas.virginia.gov](http://www.dmas.virginia.gov).

Please be specific about what action or decision you wish to appeal and include a copy of the notice about the action if you have it. Be sure to sign the letter or form.

Please mail appeal requests to:

Appeals Division  
Department of Medical Assistance Services  
600 E. Broad Street  
Richmond, Virginia 23219  
Telephone: (804) 371-8488  
Fax: (804) 371-8491

For reduction or termination of coverage, if your request is made before the effective date of the action and the action is subject to appeal, your coverage may continue pending the outcome of the appeal. You may, however, have to repay the Medicaid program for any services you receive during the continued coverage period if the agency's action is upheld.

After you file your appeal, you will be notified of the date, time, and location of the scheduled hearing. Most hearings can be done by telephone.

The Hearing Officer's decision is the final administrative decision rendered by the Department of Medical Assistance Services. However, if you disagree with the Hearing Officer's decision, you may appeal it to your local circuit court.

## **IMPORTANT ADDRESSES AND PHONE NUMBERS**

### **Local Department of Social Services in your City or County**

Check the government (blue) pages of your local telephone book for the proper contact number for the following information:

- Questions about applying for Medicaid, FAMIS Plus, or your eligibility for the program.
- Report a change in residence, income, or other significant event.
- Questions about pre-admission screening for long-term care services.
- Request Fact Sheets about Medicaid eligibility.

### **Virginia Department of Social Services**

For questions or complaints regarding the actions of staff employed by the local Department of Social Services, write the Virginia Department of Social Services, Bureau of Customer Service, 7 North Eighth Street, Richmond, Virginia 23219. You can also call the customer services hotline at 1-800-552-3431 or email your concern to [citizen.services@dss.virginia.gov](mailto:citizen.services@dss.virginia.gov).

### **Department of Medical Assistance Services**

- Appeals - For Medicaid appeal information, call (804) 371-8488.
- Dental Services, *Smiles for Children*, 1-(888) 912-3456.

- FAMIS – For information about FAMIS, call 1-866-87FAMIS, 1-(866) 873-2647.
- Fraud - To report Medicaid fraud or abuse, call the DMAS Recipient Audit Unit at (804) 786-0156 or your local Department of Social Services.
- HIPPP – Health Insurance Premium Payment Program call toll free, 1-(800) 432-5924.
- Managed Care - For information about Managed Care enrollment, call 1-(800) 643-2273.
- Long Term Care – For information or problems call (804) 225-4222.
- Recipient Helpline – For problems with bills or services from providers call (804) 786-6145, or write the Recipient Services Unit at the address on the cover of this handbook.
- Transportation – If you do not have transportation for a Medicaid covered service appointment and you are not enrolled in an MCO, call toll free, 1-(866) 386-8331.
- Waivers - For Medicaid Waiver Programs, call (804) 786-1465.

### **Internet Website Information**

- Centers for Medicare and Medicaid Services - [www.cms.hhs.gov](http://www.cms.hhs.gov)
- *Smiles for Children* – Dental Services - <http://www.dmas.virginia.gov/dental-home.htm>
- FAMIS – Family Access to Medical Insurance Security – [www.famis.org](http://www.famis.org)
- Social Security Administration – [www.ssa.gov](http://www.ssa.gov)
- Virginia Department of Health - [www.vdh.virginia.gov](http://www.vdh.virginia.gov)
- Virginia Department of Medical Assistance Services - [www.dmas.virginia.gov](http://www.dmas.virginia.gov)
- Virginia Department of Social Services - [www.dss.virginia.gov](http://www.dss.virginia.gov)

## **OTHER RELATED PROGRAMS**

### **Supplemental Nutrition Program for Women, Infants, and Children (WIC)**

WIC is a supplemental food and nutrition education program that provides vouchers for the purchase of specific nutritious foods. It provides nutrition counseling to pregnant, postpartum, or breastfeeding women, infants, and children under age five with nutritional and financial needs. Your child's doctor or EPSDT screening providers must refer eligible infants and children to the local health department for additional information and a WIC eligibility determination.

The Virginia Department of Health's Nutrition Services Team is committed to practicing and promoting good health. Contact them by calling 1-888-942-3663.

### **Head Start**

Head Start is a federally funded pre-school program that serves low-income children and their families. Contact your local school division for more information.

### **Healthy Start**

Some communities in Virginia have high percentages of low birth weights, late-term miscarriages, infant deaths, and births to teenage mothers. Pregnant women in these areas are often unable to see doctors because they don't have insurance or enough insurance. The Virginia Healthy Start Initiative (VHSI) is designed to reduce infant mortality in these urban and rural areas and small towns: Norfolk, Petersburg, Portsmouth, and Westmoreland County.

Information about Healthy Start can be obtained by contacting the Healthy Start Program Coordinator at the VDH Division of Women's and Infant's Health at (804) 864-7764.

**Early Intervention Program**

Early intervention services, also known as “Part C” of the Individuals with Disabilities Act (IDEA), are available throughout Virginia to help infants and toddlers, under age 3 who have developmental delays or disabilities, and their families.

For more information, contact: Babies Can’t Wait Program, Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services Early Intervention Office at (800) 234-1448.

**Resource Mothers Program**

Teenagers are a group at high risk for poor birth outcomes, both medically and socially. The Resource Mothers Program trains and supervises laywomen to serve as a social support for pregnant teenagers and teenage parents of infants. The program helps low-income pregnant teenagers get prenatal care and other community services, follow good health care practices, continue in school, and encourage the involvement of the infant’s father and teens’ parents to create a stable, nurturing home. For further information, contact the Division of Women’s and Infants’ Health, Virginia Department of Health at (804) 864-7768.

**Linkages with Schools**

Schools are key links in improving child health because they are in regular contact with students and parents. Schools play an important role in identifying children’s health problems and improving access to a wide range of health care services. Schools help to inform eligible children and families about Medicaid and the EPSDT Program.

## PRIVACY INFORMATION

**This Notice describes how medical information about you can be used and disclosed and how you can get access to this information. Please review it carefully.**

When you receive health care services from an agency like DMAS, that agency may get medical (health) information about you. Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, your health information is protected. Health information includes any information that relates to: (1) your past, present or future physical or mental health or condition, (2) providing health care to you, or (3) the past, present or future payment of your health care.

This Notice tells you about your privacy rights, our duty to protect health information that identifies you, and how we may use or disclose health information that identifies you without your written permission. This Notice does not apply to health information that doesn't identify you or anyone else.

### **Your Privacy Rights**

You have the following rights regarding health care information we maintain about you:

- You can look at or get a copy of health information we have about you, in most situations;
- You can ask us to correct certain information, including certain health information, about you if you believe the information is wrong or incomplete. Most of the time we cannot change or delete information, even if it is incorrect. However, if we decide to make a change, we will add the correct information to the record and note that the new information takes the place of the old information. The old information will remain in the record. If we deny your request to change the information, you can have your written disagreement placed in your record;
- You can ask for a list of the occasions we have disclosed health information about you;
- You can ask us to limit the use or disclosure of health information about you more than the law requires. However, the law does not make us agree to do that;
- You can tell us where and how to send messages that include health information about you, if you think sending the information to your usual address could put you in danger. You must put this request in writing, and you must specify where and how to contact you;
- You can ask for and get a paper copy of this Notice from us, either by phone, by mail or on our website at [www.dmas.virginia.gov](http://www.dmas.virginia.gov);
- You can withdraw permission you gave us to use or disclose health information that identifies you, unless we have already taken action based on your permission. You must withdraw your permission in writing.

## **Our Duty To Protect Health Information That Identifies You**

The law requires DMAS to protect the privacy of health information that identifies you. It also requires us to give you a Notice of its legal duties and privacy practices.

- In most situations, DMAS may not use or disclose health information that identifies you without your written permission. This Notice explains when we may use or disclose health information that identifies you without your permission.
- If DMAS changes its privacy practices, it must notify you of the changes. The new practices will apply to all health information we have about you, regardless of when DMAS received or created the information.
- As a part of their jobs with the agency, DMAS employees must protect the privacy of health information that identifies you. DMAS does not give employees access to health information unless they need it for business reasons, such as benefit decisions, paying bills and planning for the care you need. DMAS will punish employees who do not protect the privacy of health information that identifies you.

If you have any questions about this Notice or need more information on your privacy rights, you may contact the following:

### **The Office of Compliance and Security at (804) 225-2860.**

If you believe DMAS has violated your privacy rights, you may file a complaint by contacting the HIPAA Privacy hotline at (804) 225-2860. You may also file a written complaint at:

Office of Compliance and Security  
Department of Medical Assistance Services (DMAS)  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219

You may also file a complaint with the Office of Civil Rights, U.S. Department of Health and Human Services by mail at:

Office for Civil Rights, Region III  
U.S. Department of Health & Human Services  
150 S. Independence Mall West - Suite 372  
Philadelphia, PA 19106-3499

You can also call the Office of Civil Rights at phone at (215) 861-4441, by TDD at (215) 861-4440, or fax them at (215) 861-4431.

There will be no retaliation for filing a complaint.

## **How We Use Medical Information That Identifies You**

### ***1. Payment***

DMAS may use or disclose health information about you to pay or collect payment for your health care. For example, when your doctor sends a bill to Medicaid, it includes information about your illness and treatment.

### ***2. Health care operations***

DMAS may use or disclose health information about you for health care operations, such as performing quality assessments, medical reviews, legal services or auditing functions. Examples of use and disclosures of for health care operations include using or disclosing health information for case management; surveying nursing homes; or making sure providers bill only for care you receive. DMAS may contact you to tell about treatment alternatives or additional benefits you may be interested in.

### ***3. Family member, other relative, or close personal friend***

DMAS may disclose health information about you to a family member, other relative or close personal friend when:

- The health information is related to that person's involvement with your care or payment for your care;
- You have had an opportunity to stop or limit the disclosure before it happens.

### ***4. Government programs providing public benefits***

DMAS may disclose health information about you to another government agency offering public benefits if the information relates to whether you qualify for or are signed-up for Virginia Medicaid or the (Family Access to Medical Insurance Security) FAMIS program, and the law requires or specifically allows the disclosure.

### ***5. Health oversight activities***

DMAS may sometimes use or disclose health information about you for health oversight activities, and only to another health oversight agency or someone acting on behalf of a government agency.

### ***6. Public health***

DMAS may disclose health information about you to:

- A public health authority for purposes of preventing or controlling disease, injury or disability;
- An official of a foreign government agency who is acting with the public health authority; and
- A government agency allowed to receive reports of child abuse or neglect.

## ***7. Victims of abuse, neglect, or domestic violence***

If DMAS believes you are the victim of abuse, neglect, or domestic violence, we may sometimes disclose health information about you to a government agency that receives reports of abuse, neglect or domestic violence.

## ***8. Serious threat to health or safety***

DMAS may use or disclose health information about you if it believes the use or disclosure is needed, such as to prevent or lessen a serious and immediate threat to the health and safety of a person or the public.

## ***9. For other law enforcement purposes***

DMAS may disclose health information about you to a law enforcement agency official, such as the following law enforcement purposes:

- To comply with a grand jury subpoena;
- To comply with an administrative request, such as a civil investigative demand, if the information is relevant to an administrative investigation of the Medicaid or FAMIS programs;
- To identify and locate a suspect, fugitive, witness or missing person;
- In response to a request for information about an actual or suspected crime victim;
- To alert a law enforcement official of a death that DMAS suspects is the result of criminal conduct; or
- To report evidence of a crime on DMAS' property.

## ***10. For judicial or administrative proceedings***

DMAS may disclose health information about you in response to an order from a regular or administrative court, or a subpoena or other discovery request by a party to a lawsuit, when DMAS is a party to the lawsuit.

## ***11. As required by law***

DMAS must use or disclose health information about you when a law requires the use or disclosure.

## ***12. Contractors***

DMAS may disclose health information about you to one of its contractors if the contractor:

- Needs the information to perform services for DMAS; and
- Agrees to protect the privacy and security of the information.

## ***13. Secretary of Health and Human Services***

DMAS must disclose health information about you to the Secretary of Health and Human Services when the Secretary wants it to enforce privacy protections.

#### **14. Research**

DMAS may use or disclose health information about you for research if a research board approves the use. The board will ensure that your privacy is protected when your information is used in research.

#### **15. Other uses and disclosures**

DMAS may use or disclose health information about you:

- To create health information that does not identify any specific individual;
- To the U.S. military or foreign military for military purposes, if you are a member of the group asking for the information;
- For purposes of lawful national security activities;
- To Federal officials to protect the President and others;
- To a prison or jail, if you are an inmate of that prison or jail, or to law enforcement personnel if you are in custody;
- To comply with worker's compensation laws or similar laws; and
- To tell or help in telling a family member or another person involved with your case about your location, general condition and death.

**This notice was published and became effective on March 1, 2007.**

## GLOSSARY

<b>Activities of Daily Living</b>	Personal care tasks, (e.g. bathing, dressing, toileting, transferring, and eating/feeding). An individual's degree of independence in performing these activities is part of determining the appropriate level of care and service needs.
<b>Authorized Representative</b>	Person who is authorized in writing to conduct the personal or financial affairs for an individual.
<b>Caseworker</b>	Eligibility worker at the local Department of Social Services who reviews your case to determine if you are eligible for Medicaid. This is the person you would contact regarding changes, such as your address or income, or problems, such as not receiving your Medicaid card.
<b>Coinsurance</b>	The portion of Medicare, Medicaid, or other insurance, allowed charges for which the patient is responsible.
<b>Co-Payment</b>	The portion of Medicaid-allowed charges which an enrollee is required to pay directly to the provider for certain services or procedures rendered.
<b>DMAS</b>	Department of Medical Assistance Services, the agency that administers the Medicaid program in Virginia.
<b>DSS</b>	Department of Social Services, the agency responsible for determining eligibility for medical assistance and the provision of related social services. This includes the local departments of social services.
<b>EPSDT</b>	Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a program of preventive health care and well child examinations with appropriate tests and immunizations for children and teens from birth up to age 21. Medically necessary services, which are required to correct or ameliorate defects and physical or mental illnesses that are discovered during a screening examination, may be covered as a part of the EPSDT program even if they are not covered under the State's Medicaid benefit plan.
<b>FAMIS</b>	Family Access to Medical Insurance Security is Virginia's Children's Health Insurance Program that helps pay for medical care for children under age 19 and pregnant women, FAMIS MOMs. FAMIS has a higher income level than Medicaid.
<b>FAMIS PLUS</b>	An assistance program that helps pay for medical care for children under age 19 whose family income is within 133% of the Federal Poverty Limit for the family size.

<b>Fraud</b>	A deliberate withholding or hiding of information or giving false information to obtain or attempt to obtain Medicaid benefits.
<b>Generic Drugs</b>	Copies of drugs that are the same as a brand-name drug in dosage, safety, strength, quality, performance, and intended use. The Food and Drug Administration requires generic drugs to have the same quality, strength, purity, and stability as brand name drugs. Manufactures of generic drugs don't have the same investment costs as a developer of new drugs; therefore generic drugs are less expensive.
<b>Managed Care</b>	The delivery of health care services which emphasizes the relationship between a primary care provider (PCP) and the enrollee (referred to as a "medical home"). The goal of managed care is to have a central point through which all medical care is coordinated. Managed care has proven to enhance access to care, promote patient compliance and responsibility when seeking medical care and services, provide for continuity of care, encourage preventive care, and produce better medical outcomes. Most Virginia Medicaid enrollees are required to receive their medical care through managed care programs.
<b>MCO</b>	Managed Care Organization is a health plan contracted to provide medical services and coordinates health care services through a network of providers.
<b>Medicaid</b>	An assistance program that helps pay for medical care for certain individuals and families with low incomes and resources.
<b>Medically Necessary</b>	Services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the function of a malformed extremity.
<b>Primary Care Provider (PCP)</b>	The doctor or clinic that provides most of your health care needs, gives you referrals to other health care providers when needed, and monitors your health. A PCP may be an internist, a pediatrician (children's doctor), OB/GYN (women's doctor), or certain clinics and health departments.
<b>Resources (Assets)</b>	Resources include: money on hand, in the bank, and in a safe deposit box; stocks, bonds, certificates of deposit, trusts, child support payments, pre-paid burial plans; cars, boats, life insurance policies, and real property.
<b>SSI</b>	Supplemental Security Income is a federal program administered by the Social Security Administration that pays monthly benefits to people with limited income and resources who are disabled, blind or age 65 or older. Blind or disabled children, as well as adults, can get SSI benefits.

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